AMENDMENT TO H.R. ____

OFFERED BY MR. TERRY

(Medicare Prescription Drug and Modernization Act of 2003)

Strike titles I and II (relating to Medicare Prescription Drug Benefit and Medicare Enhanced fee-for-service and Medicare Advantage; Medicare Competition) and insert the following (and conform the table of contents accordingly):

TITLE I—ESTABLISHMENT OF MEDICARE PREMIUM SUPPORT SYSTEM

SEC. 101. ESTABLISHMENT OF MEDICARE PREMIUM SUPPORT SYSTEM.

The Social Security Act is amended by adding at the end the following:

''TITLE XXII—ESTABLISHMENT OF MEDICARE PREMIUM SUPPORT SYSTEM

"SEC. 2200. CONSTRUCTION; REFERENCES; GENERAL DEFINITIONS.

''(a) CONSTRUCTION OF TITLE.—The provisions of this title shall be construed to modify and supersede the provisions and operation of title XVIII to the extent such provisions are inconsistent with the provisions of this title.

''(b) REFERENCES TO MEDICARE PROVISIONS.—Any reference in any law or regulation (other than in this title) to any provision of title XVIII is deemed a reference to such provision as modified through the operation of this title.

''(c) DEFINITIONS RELATING TO MEDICARE PLANS.—

''(1) MEDICARE PLAN.—The term 'Medicare plan' means a health benefits plan which the Secretary permits to be offered by an entity that is licensed under State law

to provide health benefits plans in the State involved to Medicare beneficiaries under this title.

''(2) HIGH OPTION MEDICARE PLAN.—The term 'high option Medicare plan' means a Medicare plan that includes stop loss coverage consistent with section 2202(b).

''(3) STANDARD MEDICARE PLAN.—The term 'standard Medicare plan' means a Medicare plan that is not a high option Medicare plan.

''(4) FEHBP.—The term 'FEHBP' means the Federal Employees Health Benefits program under chapter 89 of title 5, United States Code.

''(d) OTHER GENERAL DEFINITIONS.—For purposes of this title:

''(1) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual entitled to benefits under part A of title XVIII, enrolled for benefits under part B of such title, or both.

''(2) MEDICARE TRUST FUND.—The term 'Medicare Trust Fund' means such trust fund as established under section 2211.

''PART A—PREMIUM SUPPORT SYSTEM

"SEC. 2201. OFFERING OF BENEFITS THROUGH MEDICARE PLANS.

''(a) ELECTION OF COVERAGE THROUGH A MEDICARE PLAN.—

''(1) CONTINUED ENTITLEMENT TO MEDICARE BENEFITS.—Effective January 1, 2008, in accordance with this title, Medicare beneficiaries shall continue to be entitled to receive benefits under title XVIII (as modified by this title) and with respect to medicare beneficiaries first eligible for benefits on or after January 1, 2008, shall only receive such benefits through enrollment in a Medicare plan.

''(2) ELECTION FOR CERTAIN MEDICARE BENEFICIARIES TO RETAIN CURRENT MEDICARE BENEFITS PROGRAM.—In the case of a medicare beneficiary who was first eligible for benefits under title XVIII before January 1, 2008, such beneficiaries may make a one-time, irrevocable

election, in a form and manner determined by the Secretary to continue to receive benefits for items and services for which payment may be made under title XVIII.

''(3) ENROLLMENT PROCESS.—The Secretary shall establish a process for the enrollment of Medicare beneficiaries under Medicare plans that is based, except as the Secretary may provide, upon the process for enrollment for health plans under FEHBP, including provision of information and open enrollment and disenrollment opportunities.

''(4) CONTRACT PERIOD.—Each contract under this part with an entity offering a Medicare plan shall be for a term of at least 2 years, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(5) PLAN PERIOD.—The plan period for a Medicare plan offered by an entity with a contract under paragraph (4) shall be a term of 2 years.

''(b) BENEFICIARY PROTECTIONS AND OTHER QUALIFICATIONS FOR MEDICARE PLANS.—In order to be offered as a Medicare plan under this part, except as provided in this title, the plan and the entity offering the plan shall meet the requirements applicable to health benefits plans and qualified carriers under FEHBP, including—

''(1) the offering and scope of benefits;

''(2) protections for beneficiaries enrolled in the plans; and

''(3) requirements for financial solvency.

''(c) SELECTION OF PLANS.—

''(1) IN GENERAL.—With respect to each plan period under subsection (a)(5), a medicare beneficiary shall be deemed to have elected to remain enrolled in the medicare plan in which the beneficiary was enrolled during the prior plan period.

''(2) DEFAULT.—In the case of a medicare beneficiary who fails to enroll in a medicare plan for a plan period, the

Secretary shall provide for enrollment of the beneficiary under a medicare plan offered in the State in which the beneficiary resides that the Secretary determines to be appropriate.

''(d) EXCLUSIVE PAYMENT METHODOLOGY.—Except as provided in subsection (a)(2) and other provisions of this title, for items and services furnished on or after January 1, 2008—

''(1) payment to an entity offering a Medicare plan in the amounts provided under this title shall be instead of any amounts that may be otherwise payable under title XVIII; and

''(2) only the entity offering the Medicare plan is eligible to receive payment for items and services under such title.

''SEC. 2202. STANDARD AND HIGH OPTION MEDICARE PLANS.

''(a) BENEFITS UNDER STANDARD PLANS.—Subject to section 2203(b)(2), the Secretary may approve benefits submitted under section 2203(a)(1) with respect to a standard plan only if the plan include benefits for the items and services described in subsection (d).

''(b) BENEFITS UNDER HIGH OPTION PLANS.—The Secretary may approve the benefits submitted under section 2203(a)(1) with respect to a high option Medicare plan only if the plan includes benefits required for a standard plan under subsection (a) and also includes—

''(1) rates of beneficiary deductible, cost-sharing, and coinsurance requirements that are lower than such rates applicable under standard plans under subsection (a); and

''(2) stop-loss coverage benefits that are designed to limit the application of beneficiary cost-sharing for covered benefits in a year after incurring out-of-pocket covered expenditures that exceed a limit applicable to health benefits plans under FEHBP.

''(c) REQUIREMENT TO OFFER HIGH OPTION MEDICARE PLAN.—The Secretary may not approve the offering of a standard Medicare plan by an entity under this title in an area

unless the entity also offers a high option Medicare plan in that area that the Secretary approves under this title.

''(d) BENEFITS DESCRIBED.—For purposes of this part, a Medicare plan shall provide for coverage for the following items and services that are medically necessary and appropriate:

''(1) Hospital services, including inpatient, outpatient, and 24-hour a day emergency services.

''(2) Services of health professionals, such as physicians services and services that would be physicians services if furnished by a physician but are provided by any other licensed health care professional.

''(3) Emergency and ambulatory medical and surgical services furnished by a facility that is not a hospital.

''(4) Clinical preventive services.

''(5) Services for pregnant women.

''(6) Hospice care.

''(7) Home health care and home infusion drug therapy services.

''(8) Extended care services, as defined in section 1861(h).

''(9) Ambulance services, including ground, air, and water transportation, as appropriate.

''(10) Outpatient laboratory, radiology, and diagnostic services.

''(11) Outpatient prescription drugs and biologicals.

''(12) Outpatient rehabilitation services, including outpatient occupational therapy, physical therapy, and speech pathology services.

''(13) Durable medical equipment and prosthetic and orthotic devices.

''(14) Vision care, to the same extent such services are a covered benefit under title XVIII as of the date of the enactment of this Act.

''(e) SCOPE OF BENEFITS.—Each Medicare plan shall establish the scope of benefits applicable under the plan, subject to approval by the Secretary, including the scope of outpatient prescription drugs under the plan, any formulary restrictions

for such drugs, and any copayment structure under such formulary (if any).

''(f) PAPERWORK REDUCTION.—Each Medicare plan shall comply with the provisions of part C of title XI, relating to administrative simplification and paperwork reduction with respect to health care transactions for health care providers submitting claims to health plans.

''(g) LICENSURE.—Each entity offering a Medicare plan shall be licensed under State law to provide health benefits plans in the State.

"SEC. 2203. SUBMISSION OF BENEFIT PACKAGES AND PREMIUM RATES FOR MEDICARE PLANS.

''(a) IN GENERAL.—Each entity that intends to offer a Medicare plan in a year (beginning with 2008) in a State shall submit to the Secretary, at such time (before the beginning of each open enrollment period for each year) and in such manner as the Secretary specifies, such information as the Secretary may require to carry out title XVIII (as modified by this title). Such information shall include information on each of the following:

''(1) BENEFITS.—A description of the benefits under the plan.

''(2) PREMIUM BID.—The premium proposed to be charged for enrollment under the plan.

''(b) REVIEW AND APPROVAL BY SECRETARY.—

''(1) IN GENERAL.—The Secretary shall review the benefits and premium bids submitted under subsection (a).

''(2) AUTHORITY TO NEGOTIATE.—The Secretary may negotiate with the entities offering such plans regarding such terms and conditions but may approve such a submission only if the Secretary finds that it complies with the requirements of this section and section 2202. The terms and conditions with respect to which the Secretary may negotiate include—

''(A) the scope of benefits offered under the plan;

''(B) the premium bid for the benefits so offered; and

''(C) the assumptions of the entities offering the plan with respect to cost, risk, geographic variation, and projected number of enrollees.

''(3) SPECIAL RULE FOR HIGH OPTION MEDICARE PLANS.—If information is submitted to establish that a Medicare plan is a high option Medicare plan, the Secretary shall determine whether or not the plan meets the requirements to be a high option Medicare plan.

''(4) BENEFIT APPROVAL.—Subject to section 2202, the following applies to approval by the Secretary of benefits submitted under subsection (a)(1):

''(A) IN GENERAL.—The Secretary may approve benefits submitted under subsection (a)(1) only if the benefits are not designed in such a manner that the Secretary finds that it is likely to result in favorable selection of beneficiaries.

''(B) VARIATION IN COST-SHARING.—For purposes of meeting the requirement of section 2202, the Secretary shall permit reasonable variation in cost-sharing so long as actuarial equivalence of total cost-sharing for the benefits described in such section is maintained. Nothing in this subparagraph shall be construed as preventing a Medicare plan from providing, as an additional benefit, a lower level of cost-sharing from that otherwise described in title XVIII (as modified by this title).

''(5) PREMIUM APPROVAL.—The Secretary may approve premiums submitted under subsection (a)(2) only if the Secretary finds that the premium rates are adequate in terms of actuarial soundness to assure the financial solvency of the entity offering the plan.

''(6) STATEWIDE SERVICE AREA.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), for purposes of this title, a State shall be the service area for a Medicare plan.

''(B) DISCRETION TO ESTABLISH MULTISTATE AREAS.—If the Secretary determines that medicare

plans will not be offered in a State for a plan period, the Secretary may provide for a multistate service area to ensure the offering of such plans in such State during such plan period.

''(c) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—The Secretary shall provide for activities to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options under medicare plans provided under this title in order to promote an active, informed selection among such options.

''SEC. 2204. GOVERNMENT CONTRIBUTION TOWARD COVERAGE AND BENEFICIARY PREMIUM.

''(a) PREMIUM SUPPORT PAYMENT BY GOVERNMENT.—Except as provided in subsection (d), the amount of payment to an entity offering a Medicare plan in a State for a Medicare beneficiary (other than a qualified low-income Medicare beneficiary, as defined in section 2115(a)) residing in the State who is enrolled in the plan for a year is equal to the bid amount determined or negotiated, as the case may be, by the Secretary under section 2203.

''(b) COMPUTATION AND COLLECTION OF BENEFICIARY PREMIUM.—

''(1) COMPUTATION OF TOTAL BENEFICIARY PREMIUM.—

''(A) IN GENERAL.—For purposes of this section, the amount of the total beneficiary premium for a Medicare beneficiary enrolled in a Medicare plan is equal 30 percent (or in the case of an individual to whom subsection (c) applies, the means-tested premium percentage determined under such subsection) of the amount of payment to the entity offering the Medicare plan under subsection (a).

''(B) NO APPLICATION TO QUALIFIED LOW-INCOME MEDICARE BENEFICIARIES.—For provisions relating to computation of beneficiary premiums for qualified low-income Medicare beneficiaries, see section 2205(b).

''(2) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—

''(A) IN GENERAL.—The amount of the total beneficiary premium under paragraph (1) shall be paid to the Medicare Trust Fund in the same manner as monthly premiums under part B of title XVIII were payable to the credit of the Federal Supplementary Medical Insurance Trust Fund under section 1840 (as in effect as of the date of the enactment of this title).

''(B) COLLECTION.—In order to carry out subparagraph (A), the Secretary shall transmit to the Commissioner of Social Security—

''(i) at the beginning of each year, information on the name, social security account number, and the total beneficiary premium owed by each individual enrolled in a Medicare plan for months in the year; and

''(ii) periodically throughout the year, information to update the information previously transmitted under this subparagraph during the year.

''(c) MEANS-TESTED PREMIUM PERCENTAGE.—

''(1) INCREASE IN PREMIUM AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of an Medicare beneficiary whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) is equal to or greater than 300 percent of the official poverty line (referred to in section 1905(p)(2)(A)), the Secretary shall increase the amount of the total beneficiary premium under subsection (b) for months in the calendar year by 10 percent for each multiple of 100 percent by which such individual's income exceeds 200 percent of such poverty line.

''(B) UPPER LIMIT ON PREMIUM AMOUNT.—In no case may the application of subparagraph (A) result in a premium contribution amount under subsection (b) of

greater than 70 percent of the amount of payment to the entity offering the Medicare plan under subsection (a).

''(2) DETERMINATION OF INCOME.—The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) SECRETARY'S ESTIMATE OF AMOUNT.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

''(B) MODIFICATION OF SECRETARY'S ESTIMATE.—If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) DEFAULT INCOME AMOUNT.—If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

''(3) ADJUSTMENT OF PREMIUMS TO ACCOUNT FOR MISESTIMATION.—

''(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) APPLICATION OF INTEREST CHARGE.—

''(i) IN GENERAL.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (3) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (3), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by interest in an amount equal to the sum of the

amounts determined under clause (ii) for each of the months described in clause (ii).

''(ii) COMPUTATION OF INTEREST CHARGE.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (3) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (3) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

''(iii) WAIVER OF INTEREST CHARGE.—Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (3) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) ENROLLMENT DURING A PORTION OF THE YEAR.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if

the individual were enrolled under this part for the year.

''(D) PAYMENTS TO SURVIVING SPOUSE FOR ENROLLEES WHO DIE DURING THE YEAR.—In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(4) MODIFIED ADJUSTED GROSS INCOME DEFINED.—In this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(A) determined without regard to sections 135, 911, 931, and 933 of such Code, and

''(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(d) PAYMENT TERMS.—Payment under this section or section 2205(c) to an entity offering a Medicare plan shall be made in a manner determined by the Secretary and based upon the manner in which payments are made to qualified carriers under FEHBP for health benefits plans.

''(e) SPECIAL ADJUSTMENT FOR MEDICARE BENEFICIARIES WITH END-STAGE RENAL DISEASE.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of payment to an entity offering a Medicare plan for a Medicare beneficiary under subsection (a) shall be in-

creased by 20 percent for each Medicare beneficiary who is diagnosed with end-stage renal disease.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a Medicare beneficiary who develops end-stage renal disease while enrolled in a Medicare plan.

"SEC. 2205. SUBSIDIZED PREMIUMS FOR LOW-INCOME INDIVIDUALS TO ENROLL IN HIGH OPTION MEDICARE PLANS.

''(a) QUALIFIED LOW-INCOME MEDICARE BENEFICIARY DEFINED.—

''(1) IN GENERAL.—For purposes of this part, the term 'qualified low-income Medicare beneficiary' means a Medicare beneficiary whose income (as determined for purposes of section 1905(p)) does not exceed 200 percent of the official poverty line (referred to in paragraph (2)(A) of such section) applicable to a family of the size involved and who is enrolled in a high option Medicare plan.

''(2) ANNUAL ELIGIBILITY DETERMINATION BY STATES.—The Secretary shall establish an arrangement with each State (as defined under section 1861(x) for purposes of title XVIII) under which the State provides for the determination of whether a Medicare beneficiary in the State is a qualified low-income Medicare beneficiary. A determination that a Medicare beneficiary is a qualified low-income Medicare beneficiary shall remain valid for a period of 12 months but is conditioned upon continuing enrollment in a high option Medicare plan.

''(b) PAYMENT BY GOVERNMENT ON BEHALF OF QUALIFIED LOW-INCOME MEDICARE BENEFICIARIES.—

''(1) AMOUNT.—The amount of payment to an entity offering a Medicare plan for a qualified low-income Medicare beneficiary who is enrolled in the plan for a year is equal to—

''(A) in the case of a plan that is the lowest cost high option plan offered in the State, the full premium for the plan determined or negotiated, as the case may be, by the Secretary under section 2203; and

''(B) in the case of a plan that is not the lowest cost high option plan, the full premium for the plan described in subparagraph (A).

If a qualified low-income Medicare beneficiary elects a plan referred to in subparagraph (B), the beneficiary is responsible for payment, in the manner prescribed in subsection (c), of any premium in excess of the amount payable by the Secretary under such subparagraph.

''(2) GEOGRAPHIC AND RISK ADJUSTMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish an appropriate methodology for adjusting the amount paid under paragraph (1) to take into account, in a budget neutral manner, appropriate variations in costs—

''(i) based on provision of items and services in different geographic areas; and

''(ii) based on differences in the actuarial risk of different enrollees being served.

''(B) CONSIDERATIONS.—The provisions of section 2204(b)(2)(B) shall apply to establishing adjustors under subparagraph (A) in the same manner as they apply to establishing adjustors under section 2204(b)(2)(A), except that the population for which such adjustors is computed and applicable shall be the population of qualified low-income Medicare beneficiaries.

''(c) COLLECTION OF BENEFICIARY PREMIUM (IF ANY).—The provisions of section 2204 apply to collection of premiums under subsection (b)(1)(B) in the same manner as they apply to collection of premiums under section 2204(b)(2).

''(d) CONSTRUCTION RELATIVE TO OTHER BENEFITS.—

''(1) NO REQUIREMENT FOR STATE MEDICAID PAYMENT.—Nothing in this section shall be construed as requiring a State, under its plan under title XIX, to pay any part of the additional subsidy provided under this section to qualified low-income Medicare beneficiaries.

''(2) NO MEDICAID MATCHING FOR PAYMENT.—Insofar as this section applies to an individual, notwithstanding any other provision of law, a State plan under title XIX is not required to provide medical assistance with respect to Medicare cost-sharing described in section 1905(p)(3)(A) and Federal financial assistance shall not be available under section 1903 with respect to such medical assistance.

''(3) NONDUPLICATION OF PRESCRIPTION DRUG BENEFITS.—In the case of prescription drugs provided to a qualified low-income Medicare beneficiary enrolled in a Medicare plan to the extent the beneficiary is covered under a State-funded prescription drug program, the entity offering the plan may charge or authorize the provider of such services to charge, in accordance with the charges allowed under the program—

''(A) the State program for payment for the drugs; or

''(B) such beneficiary to the extent that the beneficiary has been paid under such program for such drugs.

''SEC. 2206. RELATION TO CERTAIN LAWS; TREATMENT OF CURRENT PLANS.

''(a) IN GENERAL.—Effective January 1, 2008, the following provisions of law are modified as follows, in order to reflect the policies specified in this part:

''(1) CHANGE IN PAYMENT RULES.—Payment rates established under sections 2204 and 2205 shall supersede the payment rates and amounts applicable under parts A, B, C, and D of title XVIII in the case of individuals enrolled in a medicare plan under this title.

''(2) ELIMINATION OF ADJUSTED COMMUNITY RATE RULES.—Section 1854(f)(1)(A) (relating to requiring additional benefits) no longer applies in the case of individuals enrolled in a medicare plan under this title.

''(3) ELIMINATION OF PREMIUM REGULATIONS.—Section 1854(e) (relating to regulations of Medicare+Choice

premiums) no longer applies in the case of individuals enrolled in a medicare plan under this title.

''(4) PART B PREMIUM.—No separate premium is payable under section 1839 in the case of individuals enrolled in a medicare plan under this title.

''(5) MEDICAID PREMIUM ASSISTANCE.—Sections 1902(a)(10)(E) and 1905(p)(3)(A), insofar as they require the provision of medical assistance for Medicare cost-sharing described in section 1905(p)(3)(A) for qualified low-income Medicare beneficiaries, no longer apply in the case of individuals enrolled in a medicare plan under this title.

''(6) ELIMINATION OF RESTRICTION ON ENROLLMENT UNDER CERTAIN PLANS.—Subparagraph (B) of section 1851(a)(3) no longer applies in the case of individuals enrolled in a medicare plan under this title.

The fact that a provision is not cited in this subsection does not indicate that the provision is not modified under this title in some manner consistent with section 2200(a).

''(b) RELATION TO STATE LAWS.—Any standard established under this title or by the Secretary pursuant to this title shall supersede any State law or regulation with respect to Medicare plans which are offered by entities under this title to the extent such law or regulation is inconsistent with such standards.

''PART B—MEDICARE TRUST FUND

''SEC. 2211. MEDICARE TRUST FUND.

''(a) ESTABLISHMENT.—Effective January 1, 2008, there is created on the books of the Treasury of the United States a trust fund to be known as the Medicare Trust Fund.

''(b) AMOUNTS IN MEDICARE TRUST FUND.—

''(1) IN GENERAL.—The Medicare Trust Fund shall consist of the following amounts:

''(A) Amounts deposited in, or appropriated to, the Medicare Trust Fund as provided in this title.

''(B) Any gifts and bequests made to the Medicare Trust Fund as provided in section 201(i)(1).

''(2) APPROPRIATION OF HOSPITAL INSURANCE TAXES.—

''(A) IN GENERAL.—Beginning January 1, 2008, and for each subsequent year, there is appropriated to the Medicare Trust Fund, out of moneys in the Treasury not otherwise appropriated, an amount equal to such percent of the taxes described in paragraphs (1) and (2) of section 1817(a) that the Secretary estimates reflects the relative weight that benefits under part A represents of the actuarial value of the total benefits under this title.

''(B) TRANSFER.—The amounts appropriated pursuant to subparagraph (A) shall be transferred from time to time from the general fund in the Treasury to the Medicare Trust Fund. The amount to be transferred under this paragraph shall be determined on the basis of estimates by the Secretary of the Treasury of the taxes, described in such paragraph, paid to or deposited into the Treasury. The Secretary of the Treasury shall make adjustments in amounts subsequently transferred to the extent that prior estimates were in excess of, or were less than, such taxes.

''(3) GENERAL REVENUE CONTRIBUTION.—Beginning January 1, 2008, and for each subsequent year, there is appropriated to the Medicare Trust Fund, out of moneys in the Treasury not otherwise appropriated, from time to time, an amount equal to the amount by which the aggregate expenditures under this title (including payments made to Medicare plans under section 2204) exceed the sum of—

''(A) the amount appropriated under paragraph (2) for the period involved;

''(B) the premiums collected under sections 2204(b)(2) and 2205(c) for such period; and

''(C) the fees collected under section 2206 for such period.

''(4) APPLICATION TO OBLIGATIONS OF, AND AMOUNTS OWED TO, THE PART A AND B TRUST FUNDS.—

''(A) CERTIFICATION.—Beginning January 1, 2008, the Secretary shall periodically certify to the Board of Trustees of the Medicare Trust Fund any amounts that would otherwise be—

''(i) payable from the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund for items and services provided prior to such date; or

''(ii) due to such trust funds for items and services provided prior to such date.

''(B) TRANSFERS AND DEPOSITS.—

''(i) TRANSFERS.—If Secretary certifies an amount pursuant to subparagraph (A)(i), the Board of Trustees of the Medicare Trust Fund shall transfer to the Secretary from such trust fund an amount equal to the amount certified.

''(ii) DEPOSITS.—If Secretary certifies an amount pursuant to subparagraph (A)(ii), the Secretary shall deposit in the Medicare Trust Fund an amount equal to the amount certified.

''(c) APPLICATION OF HI TRUST FUND PROVISIONS.—Subject to other provisions of this title, the provisions of subsections (b) through (i) of section 1817 shall apply to title XVIII (as modified by this title) and the Medicare Trust Fund in the same manner as they apply to part A of title XVIII and the Federal Hospital Insurance Trust Fund, respectively.

''SEC. 2212. PROGRAMMATIC INSOLVENCY AND LIMITATION ON GENERAL REVENUE FINANCING.

''(a) ANNUAL DETERMINATIONS.—In addition to any other duties, the Board of Trustees of the Medicare Trust Fund (in this section referred to as the 'Board of Trustees') shall determine and report to Congress as part of its annual report each year the following:

''(1) The percentage of total expenditures from the Medicare Trust Fund that is financed by the general revenue contributions described in section 2211(b)(3).

''(2) The first fiscal year (if any) that the Medicare Trust Fund is projected to become programmatically insolvent (as defined in subsection (b)).

''(3) The first fiscal year (if any) in which the amounts in the Medicare Trust Fund will be insufficient to pay for the total expenses incurred under title XVIII (as revised by this title).

''(4) Recommendations to preclude the program from becoming programmatically insolvent.

''(b) PROGRAMMATIC INSOLVENCY DEFINED.—

''(1) IN GENERAL.—For purposes of this part, the Medicare Trust Fund shall be deemed to be 'programmatically insolvent' for a fiscal year if the amount appropriated to the Medicare Trust Fund under section 2211(b)(3) would exceed 40 percent of the amount described in paragraph (2).

''(2) NET EXPENDITURES ON BASIC BENEFITS.—The amount described in this paragraph is, as estimated by the Board of Trustees in consultation with the Secretary and the Secretary of the Treasury, the total expenditures from the Medicare Trust Fund in the fiscal year involved, reduced by an amount equal to the administrative expenses of the Secretary for that fiscal year.''.

SEC. 102. CONFORMING AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking ''or (14)'' each place it appears and inserting ''(14), or (19)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to the monthly premium under section 2204 of the Social Security Act for months beginning with January 2008.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(15) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2007.